Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | May 2012

ALSO IN THIS ISSUE

Lawyer's Policy Voided Based on Misrepresentation in Application, and Disbarment Order Triggers Dishonesty Exclusion

The United States Court of Appeals for the Sixth Circuit, applying Kentucky law, has held that an insured attorney's failure to disclose circumstances surrounding excessive fees paid out of a class action settlement, which ultimately led to his court-ordered disbarment and related state bar association investigation justified rescission of the attorney's professional liability policy. *Cont'l Cas. Co. v. Law Offices of Melbourne Mills, Jr.*, 2012 WL 1232599 (6th Cir. Apr. 13, 2012). The court also held that, by virtue of the disbarment order, the policy's dishonesty exclusion barred coverage for the ensuing malpractice action filed against the attorney. Wiley Rein LLP represented the insurer in the case.

The attorney, along with other attorneys, represented over 400 plaintiffs in a class action lawsuit arising out of injuries stemming from the diet drug Fen-Phen. The parties settled the case for

continued on page 10

Bankruptcy Court Lifts Automatic Stay To Allow Insurers To Pay Defense Costs

The United States Bankruptcy Court for the Southern District of New York has lifted the automatic stay in bankruptcy to permit D&O and E&O insurers to advance or reimburse insured directors,' officers' and employees' reasonable defense costs incurred in underlying litigation arising out of the insured company's collapse. *In re MF Global Holdings Ltd., et al.*, No. 11-15059 (MG) (Bankr. S.D.N.Y. Apr. 10, 2012)

Following the insured company's bankruptcy, numerous directors, officers and employees of the company were named as defendants in lawsuits brought by securities holders, commodity customers and other plaintiffs. These lawsuits alleged a variety of different causes of action and resulted in substantial defense costs. Many of these defendants, therefore, submitted notices of claims seeking coverage under the bankrupt company's D&O and E&O insurance policies. In response, the insurers sought a judicial determination that the proceeds of the policies at issue were not property of

continued on page 9

Pre-Suit Demand for Services Constitutes "Claim"

Applying Georgia law, the United States District Court for the Northern District of Georgia has held that a pre-suit letter from a claimant to an insured, which demanded that the insured resume certain suspended services and threatened legal action, was a claim first made prior to the inception of the insured's claims made policy. *Philadelphia Indem. Ins. Co. v. AGCO Corp.*, 2012 WL 1005030 (N.D. Ga. Mar. 23, 2012). In addition, the court held that a warranty exclusion in the application barred coverage for the claim because the insured had failed to disclose the pre-suit claim and instead had stated that it had no knowledge of facts or circumstances that could be the basis for a claim.

In 2005, a claims administrator entered into an agreement with an agricultural products manufacturer for the administration of extended warranty claims. After the claims administrator stopped paying the warranty claims, the manufacturer sent the claims administrator a letter in November 2008 demanding that the administrator resume payment of suspended claims and threatening legal action.

The claims administrator subsequently applied for a professional liability insurance policy. The application asked whether any claims had been made against the administrator within the past five years and whether the administrator was aware of any acts, errors or omissions that could be the basis for a claim. The application also provided that no coverage would be available for any such claims, acts, errors or omissions not disclosed in the application. The administrator answered "no" to both questions. The insurer issued the policy, which provided coverage for claims first made against the insured during the March 17, 2009 to March 17, 2010 policy period. On June 26, 2009, the manufacturer filed suit against the insured claims administrator, and the insured sought coverage under the policy. The insurer denied coverage and subsequently filed a declaratory judgment action.

On cross-motions for summary judgment in the declaratory judgment action, the court ruled for the insurer, finding that no coverage was

continued on page 12

Prior Proceeding Exclusion Does Not Bar Coverage for *Qui Tam* Action

The Supreme Court of the State of New York, New York County, has denied a motion to dismiss filed by insurance company defendants, holding that a policy's "pending and prior proceedings" exclusion did not bar coverage for a *qui tam* action brought against an insured lender. *Ciena Capital LLC v. XL Spec. Ins. Co.*, No. 651452/2010 (N.Y. Sup. Ct. Mar. 26, 2012). The court also concluded that an E&O exclusion for "[c]laims for the rendering of services to others for a fee" was ambiguous and did not bar coverage.

In September 2008, the insured lender became aware of a *qui tam* action brought against it. According to the underlying complaint, the lender had engaged in fraudulent practices in connection with certain loans. The lender tendered the claim to its insurers, which had issued separate management liability and professional liability policies. The insurers denied coverage on the grounds that the *qui tam* action was "based upon, arising out of, directly or indirectly resulting from, [or] in consequence of" other proceedings and investigations that had commenced before the start of the policy period. The insurers pointed to Securities and Exchange Commission (SEC) and U.S. Attorney investigations, charges against a vice president of the lender and a 2005 suit brought by the relators who brought the *qui tam* action.

Emphasizing the relaxed pleading standards at the motion to dismiss stage, the trial court denied the insurers' motion, concluding that "there is an issue of fact as to whether the Other Proceedings bear a substantial enough relationship to the [*qui tam* action]." In particular, the court emphasized that the specific loans at issue in the *qui tam* action were not mentioned in any documentary evidence relating to the

continued on page 10

"In Fact" Requirement Triggered By Jury's Guilty Verdict

Applying Illinois and Florida law, the United States District Court for the Eastern District of Virginia has held that a jury's guilty verdict in a criminal proceeding triggers the "in fact" element of a D&O policy's dishonesty and personal profit exclusions, allowing the insurer unilaterally to cease advancing defense costs. *Farkas v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2012 WL 966577 (E.D. Va. Mar. 21, 2012).

The insured, the chairman of a bankrupt mortgage corporation, was indicted on various criminal counts for bank, wire and securities fraud. The mortgage corporation's D&O/private company insurer agreed that the criminal proceeding constituted a claim under the policy, but reserved its right to limit or deny coverage based on certain policy exclusions. Pursuant to an order of the bankruptcy court, the parties agreed that the insurer could advance up to $1 million for the chairman's defense costs. Shortly after the chairman's criminal trial began, the insurer advised defense counsel that his invoices had exceeded $1 million and that the carrier would not advance funds in excess of $1 million without the bankruptcy court's approval. While awaiting a bankruptcy court determination, the jury found the chairman guilty on all counts. The insurer informed the chairman that the jury's verdict triggered the "in fact" element of the policy's dishonesty and personal profits exclusions, such that it would no longer advance defense costs.

> The court held that forcing the carrier to pay out amounts for which it could immediately seek recoupment was not appropriate either under the terms of the policy or as a practical matter.

In the ensuing coverage dispute, the court first held that the jury's verdict clearly triggered the "in fact" requirement of the personal profit and dishonesty exclusions, rejecting the chairman's argument that the phrase was ambiguous and

continued on page 12

Payment for Settlement of Restitution Claim Is Not an Insurable "Loss"

The United States Court of Appeals for the Seventh Circuit has held that an insured's payment to resolve allegations that the insured fraudulently induced the purchase of its subsidiary at an artificially inflated price did not constitute an insurable "loss" under Illinois law. *Ryerson Inc. v. Fed. Ins. Co.*, 2012 WL 126282 (7th Cir. Apr. 12, 2012).

The case arose out of the insured's sale of a group of subsidiaries for $29 million. After the transaction was completed, the buyer discovered that the insured had failed to disclose that one of the subsidiaries was on the verge of losing its largest customer. The buyer brought suit against the insured, alleging fraudulent concealment and that the insured had caused it to pay more for the subsidiary's stock than the subsidiary actually was worth. The buyer sought rescission of the sale and restitution of the purchase price. The insured ultimately settled the suit by making a payment of $8.5 million, which the parties described as a "post-closing price adjustment." The insured turned to its directors and officers liability insurer for reimbursement, which the insurer refused to provide on the grounds that the claim by the buyer did not present a covered risk. The district court agreed, granting summary judgment for the insurer in a decision discussed in the November 2010 issue of *Executive Summary* here.

The Seventh Circuit affirmed, finding that the settlement payment represented the return of part or all of the amount that the insured had obtained by inducing the buyer to overpay for the subsidiary. According to the court, to allow the insured to obtain reimbursement for this amount would permit the insured to "have gotten away with fraud." The court held that "there is no insurable interest in the proceeds of a fraud" and noted that "no state would enforce . . . an

continued on page 13

Severability Provisions Do Not Apply to Prior Knowledge Exclusion

The United States District Court for the Southern District of Texas has held that severability provisions in a lawyers professional liability policy do not apply to a prior-knowledge exclusion found in a separate section of the policy. *One Beacon Ins. Co. v. T. Wade Welch & Assocs.*, 2012 WL 1155739 (S.D. Tex. Apr. 5, 2012). In addition, the court denied the insured law firm's motion to dismiss, holding that the insurer's complaint seeking rescission sufficiently pleaded materiality of an earlier omitted sanctions order, even though the policy would not have afforded coverage for the type of fine in the prior order.

The insurer issued professional liability policies to the insured law firm in 2007 and 2008. Each application inquired whether any member of the firm ever had been the "subject of any complaint, grievance or action by any court, administrative agency or regulatory body." The policies each also contained a prior knowledge exclusion. After the policies incepted, sanctions were awarded against a client in two lawsuits the firm was handling, in one case resulting from motions filed in 2005. The client asked the law firm to enter into tolling agreements and the law firm tendered the matters for coverage. The insurer brought action against the firm and certain individuals seeking a declaration that the policies were void *ab initio* or, in the alternative, that the prior knowledge exclusions barred coverage for the underlying matters. The insureds moved to dismiss.

With respect to the insurer's count for rescission, the court rejected the insureds' argument that the insurer had failed to plead that any misrepresentation or omission was material. The insureds argued that their failure to disclose an earlier sanctions award from 2004, in which the firm was ordered to pay opposing counsel's attorneys fees, was not material because the policies expressly excluded coverage for attorneys fees. The court held that it was plausible that the insurer would have declined to issue the policy if the earlier sanctions award had been disclosed.

The court also rejected the insureds' arguments that the prior knowledge exclusion could bar coverage only for insureds that actually had prior knowledge of the relevant events. The insureds pointed to two severability provisions in each policy: one following the dishonesty exclusion and one contained in the policy's

continued on page 11

Despite Insurer's Breach of Duty to Defend, State Insurance Guaranty Association Can Deny Coverage Under Unambiguous Professional Services Exclusion

Applying Connecticut law, the Appellate Court of Connecticut has held that an exclusion for injury arising solely out of the rendering of professional services by individual physicians unambiguously barred coverage for a medical malpractice action. *Conn. Ins. Guar. Assoc. v. Drown*, 37 A.3d 820 (Conn. App. Ct. 2012). The court also held that a state insurance guaranty association, which became statutorily liable for the claim by virtue of insurer insolvency, was not estopped from denying coverage based on the insolvent insurer's breach of the duty to defend.

In May 2000, claimants filed a medical malpractice action against a medical association and two physicians. The medical association reported the claim under its professional liability policy, which covered professional services by persons acting as board or committee members, and the insurer provided a defense without reserving rights. Thereafter, in 2006, the insurer denied coverage under the policy's professional services exclusion and defense counsel failed to participate in a pretrial mediation, resulting in a default judgment against the medical association. Ultimately, the medical association executed a settlement agreement with the claimants in the amount of the $2 million policy limit. Then, in 2008, a bankruptcy court declared the insurer insolvent and ordered its liquidation. The Connecticut Insurance Guaranty Association (the guaranty association) therefore became

continued on page 11

Suit Alleging Failure to Provide Notice of Plan Benefits Triggered ERISA Exclusion

The United States District Court for the Eastern District of Wisconsin, applying Wisconsin law, held that an Employee Retirement Income Security Act (ERISA) exclusion barred coverage for a former employee's suit alleging violations of ERISA and the Consolidated Omnibus Budget Reconciliation Act (COBRA) arising from the insured's alleged failure to provide timely notice of plan benefits after the employee's termination. *Just v. Accu-Turn, Inc.*, 2012 WL 1067106 (E.D. Wisc. Mar. 28, 2012).

A former employee brought suit against the policyholder, his former employer, for alleged ERISA and COBRA violations after the former employee was denied plan benefits after failing to elect to continue the benefits within a specified period. The former employee also alleged that the policyholder failed to provide him with an initial notice or election notice of COBRA benefits on a timely basis. The insurer intervened in the underlying action and sought a declaration that an ERISA exclusion barred coverage for the former employee's suit. The exclusion provided that "[t]his insurance does not apply to loss for which the insured is liable because of liability imposed on a fiduciary by the Employee Retirement [Income] Security Act (ERISA) of 1974, as now or hereafter amended."

The court held that the exclusion was unambiguous and barred covered for "losses arising from a liability imposed on a fiduciary by ERISA." The court rejected the insured's contention that the allegations in the complaint arose from COBRA rather than ERISA because COBRA amended ERISA and "ERISA provides the statutory framework for a COBRA claim." The court also held that the policyholder, as plan administrator, was a fiduciary under ERISA if, as alleged, it was obligated to provide COBRA notices to the former employee and provide plan payments. The court therefore held that the insured had no duty to defend against the former employee's suit. Because the insurer had no duty to defend, the court also held that the insurer did not have a duty to indemnify the policyholder. ■

Exclusions in Real Estate E&O Policy Foreclose Duty to Defend

Applying Alabama law, a federal district court has rejected a real estate management company's claim that its insurer owes it a duty to defend underlying claims under a real estate errors and omissions policy. *Cont'l Cas. Co. v. HomeCorp Mgmt., Inc.*, 2012 WL 1067974 (M.D. Ala. Mar. 29, 2012). The court held that three separate exclusions barred coverage.

The underlying dispute arose out of a failed real estate investment. The insured real estate management company served as the property manager of the investment property. The investment property was purchased by a separate partnership indirectly owned by individual insureds working at the insured real estate management company. The insured persons each owned 17.5% of a limited liability company (LLC), which owned 92% of a second limited liability company, which in turn owned 50% of the partnership that purchased the real estate investment at issue. Other individuals who owned interests in the first limited liability company had signed guarantees in connection with the debt financing for the property, and they later sued the insured real estate management company and the insured persons, alleging that they had been misled regarding the scope of the guarantees.

In the coverage litigation, the court held that three separate exclusions applied and barred coverage for the underlying lawsuit. First, the policy's financial interest exclusion barred coverage for any claim "arising out of the actual or attempted purchase of property by . . . any entity in which any Insured has a financial interest . . . provided that such financial interest existed at the time of the act or omission giving rise to the claim." The individual insureds argued that they did not have a financial interest in the partnership that actually purchased the subject partnership. Rejecting this argument, the court referred to dictionary definitions that defined "financial interest" to include having a monetary stake in an entity and

continued on page 13

No Breach of Contract Where Excess Insurer Timely Pays After Underlying Insurer Exhausts, But Fact Issue Exists on Bad Faith

Applying Washington law, the United States District Court for the Western District of Washington denied an excess insurer's motion for summary judgment on its insured's bad faith claim, holding that, although the insurer did not breach its contract because it retracted its initial coverage denial, questions of fact existed as to whether insurer initially denied coverage in bad faith based on a prior knowledge exclusion. *Isilon Systems, Inc. v. Twin City Fire Ins. Co.,* No. 10-cv-01392 (W.D. Wash. April 10, 2012).

The insurer issued an excess policy to the insured company. In 2009, the SEC filed suit against the insured company's CFO alleging financial reporting fraud. The CFO subsequently entered into a settlement agreement without admitting or denying the SEC's allegations. The insured indemnified the CFO for his defense costs and sought reimbursement from its insurers. In July 2010, the insured sent a letter to the excess insurer advising that the underlying insurance was almost exhausted and seeking coverage for approximately $5 million in defense costs. On July 26, 2010, the excess insurer denied coverage citing a prior knowledge exclusion in its policy. In August 2010, the insured sued the excess insurer. In January 2011, the excess insurer withdrew its denial, substituted a reservation of rights and stated that it would advance defense costs once the underlying insurer had exhausted its policy. After the underlying insurer exhausted, the excess insurer timely advanced $5 million in defense costs.

The excess insurer then moved for partial summary on the insured's breach of contract, Washington Consumer Protection Act (CPA), breach of the implied covenant of good faith and fair dealing and Washington Insurance Fair Conduct Act claims. The court granted summary judgment on the CPA and breach of contract claims. The court held that the insured could not show any damages because the excess insurer performed under the contract. Specifically, under the excess policy, the excess insurer was not required to pay until the underlying insurer had exhausted its policy. Here, the excess insurer timely paid once the underlying insurer exhausted.

The court denied the excess insurer's motion for summary judgment on the insured's bad faith and IFCA claims, however. The court held that the excess insurer failed to demonstrate as a matter of law that the prior knowledge exclusion applied, *i.e.*, that the CFO had knowledge of facts and circumstances that might give rise to a claim at the time he signed the application for the excess policy. The court accordingly found that a genuine issue of material fact existed as to whether the excess insurer initially denied coverage in good faith. ■

Default Judgment Against Insureds Unenforceable Against Insurer

A federal district court, applying California law, has held that a default judgment entered against an insured real estate company and its employee to settle a suit by former clients was unenforceable against the company's insurer because the judgment was the product of fraud between the company and the former clients. *Carlson v. Century Sur. Co.*, 2012 WL 1029662 (N.D. Cal. Mar. 26, 2012). The court also held that the judgment was unenforceable against the insurer on the independent ground that it was unreasonable.

The insured real estate company and one of its realtors were sued by former clients in connection with a failed real estate deal. The company tendered the suit to the insurer, which denied coverage. The company and the realtor then agreed to a settlement with the former clients pursuant to which they would allow a default judgment to be entered against them and assign their rights against the insurer to the clients. In exchange, the clients agreed not to execute on the judgment. After the company and the realtor allowed a default judgment of $3.3 million to be entered against them, the former clients filed suit against the insurer.

continued on page 8

Exclusion Bars Coverage for Claims Against Lawyer Acting as a Mortgage Broker

A Connecticut appellate court has held that a lawyers professional liability policy excluded coverage for claims against a lawyer in his capacity as the owner of a mortgage brokerage for alleged breaches of duty in arranging and closing loans and real estate purchases. *Lancia v. State Nat'l Ins. Co.*, 2012 WL 108846 (Conn. App. Ct. April 10, 2012). The court held that no duty to defend existed, notwithstanding that the underlying complaints alleged that the insured acted as an attorney in connection with the real estate transactions.

The underlying litigation that gave rise to the coverage dispute involved a series of allegedly fraudulent real estate transactions. The insured lawyer had been sued in four underlying lawsuits by mortgage borrowers who alleged that he breached duties while acting as an attorney and as the owner of the mortgage brokerage company that provided settlement and closing services in the real estate transactions. The complaints alleged that the insured provided legal representation to the sellers in the transactions, while misleading the borrowers to believe that he was providing legal representation to them.

In the coverage litigation, the insured attorney argued that the insurer had a duty to defend because, even though the underlying complaints made allegations against him in his capacity as the owner of a mortgage brokerage, the complaints also included allegations against him as an attorney, with no connection to the brokerage. The court rejected this argument, holding that coverage was barred by a policy exclusion, which provided that there was no coverage for any claim arising out of any insured's "activities as an officer, director, partner, manager, or employee of any company, corporation, operation, or association" other than the named insured law firm. The court held that the underlying complaints were "devoid of any allegations" not predicated on the insured's role as a mortgage broker. Even if the insured's conduct in part involved the rendering of legal services—which might otherwise be covered—the court held that such conduct "arises out of and is inextricably intertwined with" the insured's conduct as the owner or principal of the mortgage brokerage and his role as a mortgage broker. Thus, the exclusion unambiguously precluded coverage, and the court held that the insurer had no duty to defend the underlying claims. ■

Former Employee's Suit for Unlawful Termination Not a Claim for "Wrongful Acts"

Applying California law, a federal district court in California has held that claims for military service discrimination are not covered as "wrongful acts" under the defendant's insurance policy. *Forest Meadows Owners Ass'n v. State Farm Gen. Ins. Co.*, 2012 WL 1205204 (E.D. Cal. Apr. 11, 2012).

A former employee sued the policyholder, alleging that she had been fired as a result of her time commitments to the Air Force Reserve, a violation of state and federal law. After its insurer denied coverage, the policyholder filed suit against the insurer.

The district court granted summary judgment in favor of the insurer. In the court's view, the underlying claim was not one for a "wrongful act" and thus not covered under the policy. The policy defined "wrongful acts" as "any negligent acts, errors, omissions or breach of duty . . . ." The court rejected the policyholder's contention that "negligent" modified only "acts" and that "wrongful acts" therefore included all manner of errors, omissions, or breaches of duty. "To conclude otherwise would result in a strained and illogical interpretation of the policy in which coverage could conceivably extend to intentional, reckless or even ultrahazardous errors, omissions and breaches of duty," the court explained. Properly construed, the policy did not cover the employee's claims because "the allegations only encompassed intentional misconduct and, as a result, could not have given rise to the potential for coverage . . . ." The court therefore granted the insurer's motion for summary judgment on the grounds that it had no duty to defend the underlying claim. ■

Suit Seeking Referral Fees from Law Firm Arises Out of Professional Services

Applying Texas law, the United States District Court for the Northern District of Texas has held that a lawsuit alleging that an insured law firm failed to split its legal fees with a claimant pursuant to a referral agreement arises out of professional services and thus triggers the insurer's duty to defend. *Shore Chan Bragalone Depumpo LLP v. Greenwich Ins. Co.*, 2012 WL 1205159 (N.D. Tex. Apr. 11, 2012).

The underlying suit alleged that, contrary to the terms of a referral agreement, the law firm had not paid the claimants any proceeds from the settlement of several patent licensing claims that had been referred to the insured by the claimants. The law firm's professional liability insurer denied coverage based on its position that the lawsuit did not "arise out of professional services" as required by the policy's insuring agreements because it involved a business decision by the law firm that was unrelated to its expertise in providing legal services.

In the coverage litigation that followed, the court held that the underlying lawsuit fell within the insuring agreements. Because the law firm provided "professional services" in the form of negotiating settlements and licensing agreements—a task that requires specialized skill and knowledge—the court held that the critical inquiry is whether the underlying lawsuit "arose out of" such services. Pursuant to Texas's broad interpretation of the phrase "arising out of," the court held that the law firm need only demonstrate that there was some direct or indirect causal connection between its professional services and the injury alleged by the claimants; the professional services did not need to be a "substantial factor" that led to the lawsuit. The court distinguished a case in which an underlying lawsuit against an attorney did not arise from "professional services" because it alleged injuries based *only* on improper billing and fee-setting practices, both of which are "properly understood as non-professional services." Here, by contrast, the insured law firm was performing legal services in the form of settlement negotiations at the time the claimants' alleged damages arose, and the insured therefore satisfied its burden of showing the requisite causal connection. ■

Default Judgment Against Insureds Unenforceable Against Insurer *continued from page 6*

In a prior coverage opinion in this case—which was reported in the March 2012 edition of *Executive Summary*—the court held that the insurer had breached the duty to defend and could be held liable for consequential damages in excess of the policy limits, but also held that the default judgment was unenforceable against the insurer because it was the product of collusion between the insureds and their former clients.

The former clients then filed a motion for reconsideration with respect to the court's rulings as to collusion. The court concluded that, in light of additional evidence from the clients, an issue of fact remained as to whether the settlement agreement was collusive. The court also went on to hold, however, that the default judgment was unenforceable on two independent grounds. First, the court determined that the judgment was the product of fraud because, as part of the settlement agreement, the insureds had signed false declarations in an attempt to manufacture insurance coverage for the former clients' suit. Second, the court ruled that the judgment was unenforceable because it was unreasonable as the former clients had sought "unrecoverable damages in an uncontested prove up hearing." Because the judgment was unenforceable against the insurer, the court held that the assignment of rights from the real estate company and the realtor to the former clients also was invalid and the former clients lacked standing to continue their suit against the insurer. ■

the debtors' estates, which would then allow the insurers to advance and reimburse defense costs even while the automatic stay was in place. In the alternative, the insurers sought to lift the automatic stay to allow them to advance or reimburse defense costs on behalf of the individual insureds. Certain customers of the company objected to the motion for relief from the stay, arguing that the use of policy proceeds to pay certain individual's defense costs would diminish the funds available to pay claims against the debtors.

Finding that sufficient cause existed to lift the automatic stay, the bankruptcy court concluded that it did not need to address whether the proceeds of the policies were property of the debtors' estates. In concluding that there was cause to lift the stay, the court first explained that the need of the individual insureds—who had a present need for payment of their defense costs—far outweighed the debtors' hypothetical or speculative need for coverage. The court further reasoned that lifting the automatic stay to advance defense costs to the individual insureds would not severely prejudice the debtors' estates, but that failure to do so would significantly injure the individual insureds.

The court also noted that certain of the policies included a "priority of payments" provision, which provided that coverage potentially afforded to individual insureds for non-indemnifiable losses must be paid before any payments made to the debtors for amounts they might pay as indemnification to the individual insureds or for covered claims against the debtors themselves. According to the court, these provisions established that individual insureds had priority to any interest that may be asserted by the debtors.

The court explained that debtors' interests in insurance policies are limited by the terms of those policies and that excising the priority of payment provisions would amount to an improper rewriting of the policies.

Relying on New York Insurance Law Section 3420(a)(1), the bankruptcy court determined that the filing of a bankruptcy petition does not change the scope or terms of a debtor's insurance policy. The court therefore held that insurers must abide by the terms of the policies, notwithstanding any other provision of the Bankruptcy Code. Finally, the court concluded that the objectors did not have a vested right in the proceeds of the policies because the objectors had not conclusively established that the debtors or individual insureds were liable for any wrongdoing covered by the policies. ■

The court further reasoned that lifting the automatic stay to advance defense costs to the individual insureds would not severely prejudice the debtors' estates, but that failure to do so would significantly injure the individual insureds.

Lawyer's Policy Voided Based on Misrepresentation in Application, and Disbarment Order Triggers Dishonesty Exclusion *continued from page 1*

$200 million, but the plaintiffs, who were not informed of the details of the settlement, received only $74 million, or 37% of the settlement, in violation of their contingency fee contracts. The remainder of the settlement was split between several attorneys, including the insured and an affiliated foundation, of which the insured was a paid board member. After the settlement, the insured attorney learned that the state bar association was investigating complaints filed against him in connection with the Fen-Phen action. In his professional liability renewal application, however, the attorney answered "No" to the question whether there were "any claims, or acts or omissions that may reasonably be expected to be a claim against the firm."

The Fen-Phen plaintiffs ultimately filed a malpractice action against the attorney and others. The insurer provided the attorney with a defense under a reservation of rights and filed suit seeking a judicial declaration that it was entitled to rescind the policy based on material misrepresentations in the policy application. The claimants in the underlying action were awarded $42 million, and the attorney was disbarred by court order for his conduct in connection with the Fen-Phen settlement.

The Sixth Circuit, affirming the trial court, held that the insurer was entitled to summary judgment on two independent grounds. First, the court held that the policy was void because the attorney made a material misrepresentation in the policy application. The court explained that, at the time of the application, the attorney knew not only of the ongoing bar association investigation, but also of his own conduct in connection with the Fen-Phen settlement that ultimately led to his disbarment. Relying on the enormity of the $200 million settlement and the underwriter's testimony, the court concluded that the misrepresentations were material because the insurer would likely not have issued the policy, or would have issued a policy with different terms, but for the misrepresentation.

Second, the court held that coverage for the malpractice action was independently barred by the policy's dishonesty exclusion, which provided that the policy did not apply "to any claim based on or arising out of any dishonest, fraudulent, or criminal or malicious act or omission by an Insured," but that the insurer would provide a defense "unless or until the dishonest, fraudulent, criminal or malicious act or omission has been determined by any trial verdict, court ruling, regulatory ruling or legal admission, whether appealed or not." The court reasoned that the requirement for a court ruling was satisfied by the disbarment order, which confirmed that the attorney personally misappropriated funds and failed to exercise professional judgment over his co-counsel. ■

Prior Proceeding Exclusion Does Not Bar Coverage for Qui Tam *Action* *continued from page 2*

earlier proceedings. In addition, the court noted that the indicted vice president had been charged with personal fraud, was not a defendant in the *qui tam* action and had not implicated the lender or its management in the charged misconduct. Thus, the court concluded, "[t]hough the [insurers] have pointed to some similarities between the [*qui tam* action] and [the] Other Proceedings, they have not conclusively established that coverage . . . is barred by the Pending and Prior Proceedings Exclusion."

The court next held that the management liability policy's E&O exclusion for "[c]laims for the rendering of services to others for a fee" did not support dismissal. According to the court, the undefined term "services" did not unambiguously apply to the insured's loan origination and servicing activities. If the insurers had intended to exclude claims arising from such activities, the court reasoned, they could have defined "services" to include loan origination and servicing as they did in the professional liability policy. As a result, the court denied the insurers' motion to dismiss. ■

Severability Provisions Do Not Apply to Prior Knowledge Exclusion *continued from page 4*

notice requirement. The court held that each severability provision clearly applied only to the section in which it was contained, not to all policy provisions.

The insureds further asserted that it was illogical that the policy would contain a severability provision protecting innocent insureds in the case of fraud or dishonesty by one insured but no severability provision to protect innocent insureds from operation of the prior knowledge exclusion when the policy application was negligently completed. The court noted that prior knowledge exclusion is "designed to ensure that only risks from unknown losses are insured." The court further reasoned that "[t]he firm has control over the extent of its inquiry into prior wrongful conduct."

Finally, the court disagreed that the application question requiring disclosure of past complaints, grievances or actions against the insured was ambiguous. The insureds argued that the insurer's broad reading of the question was "absurd" because it would require insureds to disclose even sanctions for trivial violations of court rules that were not within the policy's coverage. The court responded that "[i]t is reasonable . . . to inquire about such fines even if the policy does not cover them because [the insurer] may conclude that an attorney who is willing to disregard court rules . . . may also be willing to disregard other, more substantive rules." ■

Despite Insurer's Breach of Duty to Defend, State Insurance Guaranty Association Can Deny Coverage Under Unambiguous Professional Services Exclusion *continued from page 4*

statutorily liable for claims covered under the medical association's policy and filed suit, seeking a judicial declaration of the rights and obligations of the parties with respect to the underlying action.

The court held that the professional services exclusion of the policy unambiguously barred coverage for the medical malpractice action. The exclusion provided that the policy did not cover "injury arising solely out of acts or omissions in the rendering or failure to render professional services by individual physicians or nurse anesthetists, or by any paramedical for whom a premium charge is shown on the declarations page." The court held that the use of a comma, the repeated use of the disjunctive "or" and the repeated use of "by," as well as the last antecedent rule of contract interpretation, grammatically separated the exclusion such that the phrase "for whom a premium charge is shown on the declarations page" only modified the "paramedical" category. The court also held that the initial coverage grant for "injury arising out of the rendering of or failure to render . . . professional services by any person for whose acts or omissions the corporation/partnership insured is legally responsible" was broader than the exclusion and thus that coverage was not illusory. The court explained that the exclusion would not apply if, for example, the injury arose partially out of the acts or omissions of a physician and partially out of the acts or omissions of a non-scheduled paramedical.

In addition, the court held that the guaranty association was not estopped from denying coverage due to the insolvent insurer's breach of the duty to defend. The court explained that the plain language and purpose of the guaranty act was to provide a limited form of protection to policyholders and claimants in the event of insurer insolvency for claims arising out of the policy. The expansion of this liability, according to the court, would strain the statute beyond its intended purpose of benefiting consumers by increasing premiums paid by policyholders. ■

Pre-Suit Demand for Services Constitutes "Claim" *continued from page 2*

available under the policy for the manufacturer's claim. The court held that the November 2008 letter from the manufacturer made a demand for services and thus it was a claim made prior to the inception of the policy, which defined "claim" to mean, in relevant part, "a demand received by you for money or services." In addition, the court held that all claims arising out of the administrator's denial of the warranty claims constituted related claims that would be treated as a single claim pursuant to the policy's related claims provision, which provided that all claims "based on or arising out of the same act or circumstance, or a series of similar or related acts or circumstances shall be considered a single claim." Because all claims against the insured claims administrator were deemed first made prior to the policy's inception, the court held that the insurer had no duty to defend or indemnify any claims arising from the insured administrator's denial of the warranty claims.

The court separately held that, because the November 2008 letter was a claim, the insured had incorrectly answered the application question regarding past claims. In addition, the court held that the insured had knowledge, at the time it completed the application, of a dispute that could be the basis of a claim. Thus, the court held that no coverage was available for any claims arising from the insured's failure to administer claims due to the insured's misrepresentations in the application.

Finally, the court also found that the insured claims administrator's decision to cease payment of warranty claims was intentional and thus not a "wrongful act," which the policy defined as a "negligent act, error or omission committed or alleged to have been committed by you . . . in the rendering of professional services." Consequently, the court held that the insured's conduct was not covered. ■

"In Fact" Requirement Triggered By Jury's Guilty Verdict *continued from page 3*

holding that the insurer could properly refuse to advance further defense costs without first obtaining a declaratory judgment that the exclusions barred coverage. In light of the overwhelming evidence of his guilt, the court deemed it irrelevant that the chairman was pursuing an appeal of his conviction.

The court next rejected the insured's argument that the carrier was obligated to advance *all* defense costs incurred prior to the jury's verdict—including the defense costs in excess of $1 million that were incurred while the parties awaited the bankruptcy court's determination—and then seek reimbursement on the basis that the dishonesty and personal profit exclusions barred coverage. Noting that this was not a case where the carrier had "dragged its feet before advancing costs," the court held that forcing the carrier to pay out amounts for which it could immediately seek recoupment was not appropriate either under the terms of the policy or as a practical matter. Finally, the court held that the insurer's filing of a claim against the insured mortgage corporation in the bankruptcy proceeding did not preclude it from simultaneously seeking recoupment from the chairman, as any payment from the bankruptcy estate would "simply offset" the funds that could be recouped from the chairman as an individual. ■

Payment for Settlement of Restitution Claim Is Not an Insurable "Loss" *continued from page 3*

insurance policy" that included the disgorgement of such proceeds within its definition of "loss." More broadly, the court recognized that a claim for restitution, whether based on fraud or an innocent mistake, "is a claim that the defendant has something that belongs of right not to him but to the plaintiff." Citing its prior decision in *Level 3 Communications, Inc. v. Federal Insurance Co.*, 272 F.3d 908 (7th Cir. 2001), the court concluded that having to surrender or return that "something" is not a "loss [to the insured] within the meaning of the insurance policy."

The court rejected the insured's reliance on the fact that the buyer styled its claim as one for "damages" as opposed to "restitution," finding that it is not the "label" but rather the nature of the remedy that is determinative. The court did recognize, however, that "[a] judgment or settlement in a fraud case could involve a *combination* of restitution and damages [such that] the insurance company would be liable for the damages portion in accordance with the allocation formula in the policy." In this regard, the court noted that the buyer, along with the inflated purchase price, sought to recover "transaction costs," reimbursement for which "would not be restitution because [the insured] gained nothing from the money that [the buyer] paid its lawyers and accountants to handle the acquisition." Nonetheless, the court held that because the insured admittedly "made no effort to allocate its loss between the loss of ill-gotten gains and other costs," any claim to recover those costs under the policy was "forfeited."

The court also rejected the insured's contention that the "mend the hold" doctrine precluded the insurer's "no loss" argument here because the insurer had not raised it as a ground for denying coverage when the insured first requested coverage. According to the court, the doctrine does not forbid an insurer in a breach of contract case from adding a defense to coverage after being sued. The court reasoned that requiring the insurer to commit to a defense or defenses before being sued would be "unreasonable to the point of absurdity." ■

Exclusions in Real Estate E&O Policy Foreclose Duty to Defend *continued from page 5*

held that the individual insureds had such a stake in the success of the property. According to the court, if the property "did well, then by the terms of the operating agreements, a percentage of the profits would flow to [the partnership], then to [the second limited liability company], followed by [the first limit liability company] and its members, which includes the individual [insureds]." The court held that the individuals had a financial interest in the entity purchasing the property and that the financial interest exclusion thus applied.

Another exclusion provided that the insurer had no duty to defend "any claim . . . based on or arising out of the formation, syndication, operation or administration of any property syndication, real estate investment trust or any other form of corporation, general or limited partnership or joint venture formed for the purpose of investing in, buying, selling, or maintaining real property." The court held that this exclusion applied because the underlying claims arose out of the first limited liability company's financing and acquisition of the investment property.

A third exclusion provided that the insurer had no duty to defend "any claim . . . based on or arising out of the Insured's interests, operations, or activities as . . . [a] property developer." The court held that the exclusion applied because the insured persons formed the first LLC to develop real estate, used the LLC to purchase the investment property and executed guarantees and persuaded others to execute guarantees to finance the project.

Accordingly, the court found that the insurer had no duty to defend the underlying claims. ■

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